

Just Culture

by Capella Healthcare



WHAT'S COVERED

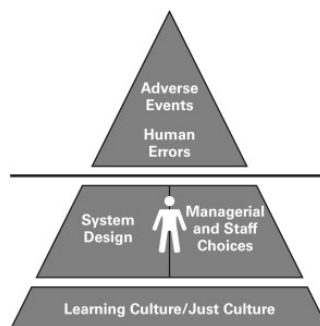
In this lesson, you will learn about just culture. Specifically, this lesson will cover:

1. How Does Just Culture Work?
 - a. Human Error
 - b. At-Risk Behavior (Gambling)
 - c. Reckless Behavior
2. Summary of Manageable Behaviors

1. How Does Just Culture Work?

Just Culture is about

- creating an open, fair, and just culture
- creating a learning culture
- designing safe, reliable systems
- managing behavioral choices



Just Culture is a way to change culture by becoming more proactive and less reactive to events. We can create such a culture by focusing on risk and system design and managing behavioral choices with less emphasis on events, errors, and outcomes. Instead we focus on manageable behaviors in the system (human error, at-risk behavior, and reckless behavior) while creating the psychological safety that allows people to freely report errors, bad processes, and near misses.

1a. Human Error

Humans are not perfect, so any system design should anticipate and mitigate some naturally occurring errors. Anyone can have a lapse, slip, or mistake. Such an event should be treated as an opportunity for improvement, not a punishable action. Even one human error is an early warning sign of a vulnerable system that needs review. The best way to manage is consoling and looking for opportunities to mitigate the risk.

➡ **EXAMPLE** While a doctor is writing orders, she is interrupted and inadvertently selects the wrong lab test for a patient. Distraction might have caused the mistake. An option for avoiding this situation could be to create a "no interruption" zone for physicians to use when engaged in documentation.

1b. At-Risk Behavior (Gambling)

Many rules, regulations, standards, guidelines, and policies serve as safety guardrails that help us avoid risk. People tend to go outside of the guardrails, a behavior often called "drift", when they have a greater workload, or it is easier to do something another way than following rules. They fail to see the hazard that lies ahead. Successful avoidance of the hazard when they drift from the guardrails reinforces the practice, allowing it to become the norm instead of the initial safe practice. This problem can be mitigated by coaching, teaching how to make better choices, and reviewing risks and hazards.

🔗 **EXAMPLE** The speed limit is 55 MPH, which data has shown to reduce accidents. You are aware of the speed limit but drive 65 MPH anyway to keep pace with traffic. Everyone knows that the police will not ticket people unless they go more than 10 miles over the speed limit. This is called normalized deviation. You have deviated (drifted) from the rule so often it becomes the norm, or the new speed limit. You fail to see the potential risk of accidents.

1c. Reckless Behavior

In very rare occasions, people choose to knowingly disregard safety and place themselves or others in harm's way. They are fully aware of the risk and can understand the harm. This is a matter of placing their own self-interests above the patient or organization. Such an action is punishable.

🔗 **EXAMPLE** True Confessions: An NBA star was arrested for driving 125 MPH in a 65 MPH zone. He stated he knew the speed limit but wanted to see how fast his car would go. He understood he could possibly kill someone but did it anyway. His license was suspended, and he was fined for violating the law.

REFLECT

Can you think of a situation in your practice where one of these behaviors may have led to an error? What steps were taken to lower risk?

2. Summary of Manageable Behaviors

Manageable Behavior	Description	How to Manage	Example
Human Error	Product of Our Current System Design and Behavioral Choices	Manage through changes in <ul style="list-style-type: none">• Choices• Processes• Procedures• Training• Design• Environment	Console
At-Risk Behavior	A Choice: Risk Believed Insignificant or Justified	Manage through <ul style="list-style-type: none">• Removing incentives for at-risk behaviors• Creating incentives for healthy behaviors• Increasing situational awareness	Coach
Reckless	Conscious Disregard of	Manage through	Sanction

Behavior	Substantial and Unjustifiable Risk	<ul style="list-style-type: none"> • Remedial action • Punitive action 	
Adapted from Marx, David. (March 27, 2018). Just Culture: A Strategic Perspective presentation.			

When an event or near miss occurs, it is important to look at it in a systematic way. James Reason and David Marx have both developed algorithms for reviewing behaviors and actions surrounding an event and managing the behaviors. It is imperative for risk management, legal, and human resources (HR) to agree on an algorithm and use it every time there is a near miss or error. Nurses, clinicians, and staff will trust the system when it is followed consistently. All leaders must be trained to use the algorithm and supported by human resources and risk management in reviewing the event. All staff and clinicians should also be trained on just culture and the algorithm so they understand how these events can occur and how to manage them.

A question that often arises is what to do when an individual repeatedly engages in at-risk behaviors and makes errors. To determine a course of action, first look at each event separately and identify any contributing systems issues. If any are found, identify system failures and redesign the system to produce the intended outcome. If there are no systems issues involved, the course of action is to consider remedial disciplinary action with Human Resources or others that handle such matters.

Just culture is a journey and will need strong leadership support and behavior modeling. Commitment and consistency in reviewing events are essential and must become a way of life, become the way people do things in the organization. A visitor at a Boeing plant was ascending a stairway to a meeting room and was told he must hold the handrail to prevent falls. This policy is the result of a just culture and a safety culture. It has become the way people do business. It is expected of everyone, even visitors. This team did not hesitate to speak up for safety.

Authored by Cindy Ebner, MSN, RN, CPHRM, FASHRM

Support

If you are struggling with a concept or terminology in the course, you may contact **RiskManagementSupport@capella.edu** for assistance.

If you are having technical issues, please contact **learningcoach@sophia.org**.